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Accessing Substance Abuse Treatment: Issues for Parents Involved with Child Welfare Services

Anna Rockhill, Beth L. Green, and Linda Newton-Curtis

The complex issues associated with barriers to treatment entry for parents who are involved with child welfare has not been well explored. Accessing *timely* treatment is now critical for these parents since the introduction of the Adoption and Safe Families Act of 1997, limiting the time until a permanency decision is made. Using a longitudinal, qualitative approach, substance-abusing parents from 15 families, their relevant family members, and service providers were interviewed approximately every 3 months over an 18-month period. The experiences of these parents add to our knowledge of the unique barriers this population faces, and expands our understanding of the mechanisms by which certain barriers may delay treatment.

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Introduction

There is little question that substance abuse is a major issue confronting families who are involved with child welfare services (CWS). Studies indicate that problems with alcohol and drug use are present in 40 to 80% of the families known to child welfare agencies (Department of Health and Human Services [DHHS], 1999; Tracy, 1994). Further, alcohol and drug abuse is associated with more severe child abuse and neglect, and is indicated in a large percentage of neglect-related child fatalities (Tracy, 1994). Finally, a study done by the National Center on Addiction and Substance Abuse (CASA; 1999) found that parental substance abuse and addiction is the “chief culprit” in at least 70% of all child welfare spending.

With the passage of the federal Adoption and Safe Families Act (ASFA) of 1997, the complex issues involved in dealing with substance-abusing parents who are involved with the child welfare system have become the focus of increased attention. Under ASFA, substance-abusing parents have as little as one year in which to comply with reunification requirements, including attaining and demonstrating recovery from their addiction, or face permanent termination of their parental rights.

Considerable controversy has surrounded this legislation—in particular, concerns about its influence on families with substance abuse problems. Many in both child welfare and substance abuse treatment services have been concerned that a 12- to 15-month time frame is inadequate for parents to successfully enter and complete court-ordered treatment, given the obstacles to treatment entry, as well as the nature of the cycle of addictive disease (CASA, 1999; Larsen, 2000; Department of Health and Human Services, 1999; Young, Gardner, & Dennis, 1998). Simply entering treatment, even when court-mandated, is a significant challenge. Indeed, a review of the substance abuse treatment literature suggests

that the obstacles associated with treatment access are many. However, little research has focused specifically on barriers to treatment access for adults involved with the child welfare system.

This paper seeks to start to fill this gap. We begin with a review of the literature most relevant to the experiences of the adults in our study. We then provide an overview of our methodology. We present our findings by first reviewing the experiences of parents who are working with child welfare in comparison to what has been described in the general substance abuse research literature. We follow this with a description of barriers not well-represented in this research but that proved significant for adults in our study. We conclude with a brief discussion of the similarities and differences between the experiences of child welfare-involved parents and other substance-abusing adults.

Literature Review

A great deal of research on treatment seeking and entry exists. This literature has identified a range of barriers shown to have significant implications for the individual who seeks substance treatment. For example, Porter (1999) suggests that the number one barrier to treatment is motivation: “[Y]ou have to want it.” In fact, this barrier is widely cited as the primary impediment to treatment seeking for both drug users and alcoholics (Ebener & Kilmer, 2003a; Thom, 1986). Barriers such as wait lists and documenting eligibility have also proved problematic for a wide range of individuals (Ebener & Kilmer, 2003a; Kline, 1996; Porter, 1999; Wenger & Rosenbaum, 1994). For example, Ebener and Kilmer (2003b) describe how both long waiting lists for treatment entry and long delays between assessment and intake give the person time to change his or her mind.

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Research also suggests that importance differences in terms of the barriers are most salient for subgroups of substance abusers. For example, while the stigma associated with female drunkenness may interfere with women's treatment seeking, for men, the fact that drinking heavily is often seen as an appropriate and even prototypical masculine behavior can inhibit their ability to see drinking as a problem (Finkelstein, 1994; Lex, 1990, 1991; Thom, 1986). Parental status also seems to influence treatment seeking differently for men and women. Specifically, a number of studies suggest that concerns around children and parenting responsibilities are a major deterrent to treatment entry for women, but not for men. Mothers are reluctant to seek treatment due to fear of losing their children to state custody, worries about who will look after their children or how to pay for child care while they are in treatment, and the length of time treatment will take them away from their family (Ebener & Kilmer, 2003b). Finally, research indicates that while men generally receive support for treatment entry from their partners, women often receive far less support or are actively discouraged from pursuing treatment; spouses may even use violence as a way to discourage women's treatment entry (Wenzel, Koegel, & Gelberg, 1996).

Minority ethnic and racial groups may also face specific barriers. These may be related to language (Porter, 1999) or other features of the culture, such as the role of "respeto" or machismo in hindering Hispanic males who may feel their personal integrity threatened by being labeled an addict (Kline, 1996). Alternately, "sympathia," which stresses harmony and the avoidance of interpersonal conflict, decreases the likelihood that a Latina will be confronted about her addiction by members of her social network (Kail & Elberth, 2002). Additionally, being embedded in a minority culture may restrict knowledge of treatment programs available within the community at large thus further compromising an individual's ability to seek treatment (Kail & Elberth, 2002; Kline, 1996). Finally, the perception that shame or loss of face could be brought upon the family seems to play out differently in different cultural groups (Ja & Aoki, 1993).

Socioeconomic status matters as well. For instance, lack of income is cited in the literature as a barrier to treatment both directly, in terms of the inability to pay for treatment (Beckman, 1994; Copeland, 1997; Copeland & Hall, 1992; Westley, 2001), and indirectly, in terms of concerns about loss of income due to time in treatment, worries about child care costs, and so on (Beckman & Amaro, 1986; Copeland, 1997). Shortages in publicly funded treatment also limit access for many substance-abusing individuals (Farabee & Leukefeld, 1998; Wenger & Rosenbaum, 1994).

Taken together, the literature summarized is suggestive of some of the challenges adults involved with the child welfare system are likely to face in attempting to access treatment. These adults are positioned at the intersection of CWS and the publicly funded treatment system, and they therefore face many of the bureaucratic hurdles already described. Secondly, they are also by definition parents (and their partners); the discussion regarding the influence that gender, parental status, and child-rearing responsibilities have on treatment access is indicative of the complexities that parents are likely to face. Thirdly, these families are disproportionately members of racial and ethnic minority groups (Courtney & Barth, 1996), and the research cited previously makes clear the importance of considering the role of race and ethnicity in treatment seeking. Lastly, these families are also disproportionately poor (Lindsey, 1994; Pelton, 1989; Shireman, 2003), and poverty has a significant impact on treatment access. The current study explores, using a qualitative approach, these complex issues for parents with substance abuse issues who are involved with the child welfare system.

Methodology

This study was conducted as part of a larger project whose goal was to examine the impact of the ASFA on families with substance abuse issues (Green & Rockhill, 2004). Data for this paper were derived from case studies of 15 families involved with the child welfare system in a major metropolitan area in a western state.

Families were identified as “substance abusing” if substance abuse was indicated as contributing to the maltreatment of the children on the family’s court petition, or was mentioned in the protective service worker’s referral narrative. Generally, child welfare workers (screeners or protective services workers) determine whether substance abuse is a presenting issue through interviews with parents, children, mandatory reporters, and other collateral contacts. A formal substance abuse assessment has not typically occurred at this point; such an assessment usually occurs after jurisdiction has been established and a service plan has been developed.

It should be noted this study took place in a county that maintained a program whereby substance abuse assessment and advocacy services were located on site at the courthouse. Thus, parents could receive preliminary assessments, referrals, and transportation immediately following the preliminary hearing if they consented. Not all of the parents in our study availed themselves of this program, however. It is also the case that the urban setting meant there were a relatively large number and wide variety of treatment services available locally.

Sample

Families who had at least one child placed in some form of substitute care and had substance abuse identified as a problem by child protective services were referred to the research project by the state’s public child welfare agency shortly after their children were placed and the initial court hearing was held. Once identified, a letter was sent to parents describing the study and a phone call was made by a researcher requesting their participation. Of the 19 families referred by CWS, 17 agreed to participate. Two of these were subsequently deemed ineligible for the project due to the fact that their children returned home very quickly and therefore ASFA was not relevant to their case.

The 15 families included 22 adults (parents and their partners) who were actively involved with CWS. Five of the families were headed by adults who were members of cultural minority groups:

four African American and one Latina. This is a slight overrepresentation of minority families relative to the child welfare population in our state, where typically about 25% of the population are members of ethnic or racial minority groups. Threat of harm ($n = 7$) and neglect ($n = 5$) were the most prevalent types of child maltreatment. Two families entered the child welfare system because an infant tested positive for drugs at birth. The parents' drug of choice varied; two parents used only marijuana, three used alcohol, and the rest used methamphetamines, heroin, cocaine, or some combination. Comparable information is not available for the general child welfare population.

The average time it took to enter substance abuse treatment for women ($n = 15$) was 71 days, standard deviation 71 days; for men ($n = 6$) 99 days, standard deviation 79 days. Two of the mothers were already in treatment when their child entered substitute care, six entered treatment within the first month, five entered treatment between one and a half months and three and a half months, and two mothers took seven months or more to enter treatment. One father entered treatment 10 days after his child entered care, three entered treatment between two and four months later, and one father took eight months to enter treatment. (We do not have information about the timing of treatment entry for one father.) All of the 22 parents in the study made it at least as far as intake, and all but 2 received at least some treatment services beyond intake. Seven parents graduated from treatment, two completed but did not "graduate," six dropped out, three were still in treatment at the time the study concluded, and we lacked definitive information on the status of the remaining three parents.

In addition to interviewing family members, researchers asked parents to identify family members and service providers (primarily CWS caseworkers, attorneys, and substance abuse providers) who were relevant to their case, and to provide permission for us to contact these individuals with questions about case progress, status, and outcomes, and all of the parents did so. However, eight providers (10%) either tacitly or actively declined our request for

interviews. Ultimately, 120 interviews were conducted with 22 parents and 6 extended family members; and 168 interviews were done with 28 CWS caseworkers (both protective services and ongoing/permanency workers), 19 parents' attorneys, 26 treatment counselors, and 3 "other" providers (a public health nurse, a child development specialist, and an outreach worker).

Interview Protocol

Interviews were qualitative and semistructured; participants were asked about the factors that facilitated or hindered the family's progress on their case plan as well as to describe what had happened with the case. Interviews were scheduled to coincide with key events during the case such as court hearings, treatment entries and exits and changes in the child's placement. They occurred, on average, every three months, although there was wide variability. At each time point, we contacted the family as well as the set of involved providers to request an interview. Families were tracked for a period lasting between 17 and 27 months; interviews ceased when a final decision regarding a permanent placement for the child was made or when the study's data gathering window closed. A total of 288 interviews were conducted; this included a high of 37 interviews and a low of 8 for a single family with an average of 19 interviews per case. The number of family member interviews ranged from 2 to 15 with an average of 8, and the number of service provider interviews ranged from 6 to 24 with an average of 11. Interviews were taped when participants consented and verbatim transcripts were produced.

This design affords the opportunity for a richly detailed picture of the experiences of these families, obtained from a wide range of perspectives including those of the parents, other family members, and the service providers involved in each case. The vast majority of participants were interviewed more than once, which allowed them to revisit and refine interpretations of events and to share understandings that unfolded over time. The event-driven nature of the longitudinal design, where interviews were conducted quickly

after key events, also meant that incidents and circumstances were still recent as they were being described and thus less susceptible to memory distortions. In addition, the practice of repeated interviews allowed us to establish relationships with parents and many providers that resulted in what we believe to be a more forthright and nuanced account than would have been shared in a cross-sectional, single time-point design (Fontana & Frey, 1994).

Analysis

Our emphasis on providing a representation of families' experiences that was both comprehensive and multifaceted was also reflected in the analysis process. To that end, a variation on the standard "constant comparative method" was employed (Lincoln & Guba, 1985). In short, following the initial coding of the interview transcripts, our primary interpretive strategy was to hold a series of dialogs involving, at first, dyads discussing a single case, and subsequently, multiple team members (interviewers, the Project Manager and the Principal Investigators) in which two to four cases were "compared." Reflecting the broader goal of the project, understanding the impact of ASFA on substance-abusing families, the focus of these discussions was "what helps and what hinders parents from making timely progress on their case?" By involving a diverse team that included a mix of genders, racial and ethnic backgrounds, and socioeconomic status, we were able to increase the range of perspectives "listening to" and "seeing" the data. This analytic triangulation (Patton, 2002) facilitated a more complete view of the families' experiences and, coupled with the comparison across cases, decreased the possibility of interpretive bias (Strauss & Corbin, 1998).

Analysis occurred simultaneously to data collection. Weekly team meetings focused on identifying the features of the systems that impacted parents' progress and included a discussion of emerging "key themes"; substance abuse treatment emerged early on as a critical issue for families. The initial coding of the interview transcripts, done by staff other than the interviewers, began with this list, although new emergent themes were actively sought. Based on the initial

coding and a dialog between the coder and the interviewer, “case summaries” were produced that included a brief description of the various key themes (substance abuse treatment among them) along with case characteristics and a narrative of the families’ progress.

Approximately two-thirds of the way through the data collection, the entire research team commenced a series of cross-case dialogs typically including three to four cases. Participants had varying degrees of knowledge about each case having either conducted the interviews, read all the interviews, read some interviews, or reviewed supporting documents such as case summaries. Everyone was encouraged to ask questions and to offer insights and alternative interpretations: This method of analysis retained the intimacy the interviewer had with the case while bringing to bear the perspectives other researchers brought to the project. This method also ensured rigor, as participants were required to defend their interpretations to the whole group and those that were less closely tied to the data were weeded out.

The “substance abuse” theme provided the bulk of data included in this paper and analysis of this theme proceeded as follows. A preliminary list of subthemes was generated that was then compared against examples from all 15 cases. Subthemes were issues related to the primary theme that focused on explaining the impact of the theme on the case. In this analysis, subthemes were generated to explain how parents’ access to treatment was supported or hindered. The final step involved investigating the relative level of impact of each subtheme on the cases, and the level of evidence for each subtheme. Subthemes for which there was a great deal of confirmatory evidence, as well as those that impacted only a few cases, but for whom it was a primary determinant of what happened, were included in our final set of findings.

Results

In what follows, we provide a detailed description of the attempts of parents involved with the child welfare system to access sub-

stance abuse treatment. Our results begin with an investigation of the extent to which barriers described in existing research are problems for these families, then we examine additional barriers they face that have not been described in extant literature on the topic. Throughout, we attempt to be sensitive to the fact that barriers do not exist in isolation, and offer preliminary observations regarding the interactions between the various factors that influence treatment access. By examining in detail the ways in which certain factors are problematic, we also provide new information about barriers to treatment access that is relevant for other substance-abusing populations. This idea may be explored further in the discussion section.

Denial of Substance Abuse Problem

Denial or “not being ready to give up drugs” is frequently cited as the most common reason for not seeking treatment among both drug users and alcoholics (Ebener & Kilmer, 2003a; Thom, 1986). Given that substance abuse per se had been identified as a problem for these families by child protective services and may in fact have precipitated their involvement with child welfare, most of these parents were likely in denial about their addiction; at the very least, these parents were not seeking treatment prior to coming into contact with child protective services. However, the fact of child welfare involvement, which included a mandate from the court to participate in addiction services as a condition of reunification, meant that parents had to comply by seeking treatment or risk the termination of their parental rights. Almost to a one, parents in our study made a serious effort to enter treatment in that they followed through on referrals by phoning providers and showing up for appointments.¹ Numerous studies have found traumatic life events as providing the impetus for treatment seeking (Famularo, Kinscherff, Bunshaft, Spivak, & Fenton, 1989; Rittner &

¹We should acknowledge that denial remained a significant barrier to engagement and treatment completion for some parents.

Davenport, 2000), and the need to 'stop' for someone else has also been given significant mention (Bammer & Weekes, 1994; Kail & Elberth, 2002; Wenger & Rosenbaum, 1994). It appears, for many of our families, that child welfare involvement served as the proverbial wake-up call and facilitated a rapid and sincere effort to pursue treatment on the part of these parents:

I'm just going to go on and do what I've got to do now because I don't ever want them [CWS] involved again, in my kids' life or my life. That was traumatic, they ain't never gone through nothing like that. I'm definitely going to get it [be engaged in treatment] this time and I can't traumatize my kids anymore like that, or myself. No, I'm glad I'm here and I'm glad I'm getting what I need, I'm glad it's helpful for me and my kids and I ain't going through this again.

Lack of Information About Treatment

Lack of information regarding treatment options has also been cited as a barrier to treatment in a variety of studies. A few of the parents had personal knowledge about addiction services; for example, some of the African American mothers had more knowledge about culturally appropriate services than CWS staff. That being said, CWS virtually ensured that *all* parents were made aware of available treatment services by, at a minimum, providing parents with a list of potential providers and their phone numbers. Moreover, parents frequently received considerable case management support in terms of actually securing an appointment for intake and assessment. This front-end assistance was typically provided by the child welfare caseworker or the staff at the court. Not surprisingly, few of the parents in our study complained about not being able to locate potential treatment services.

Logistical Issues

Structural and programmatic barriers such as wait lists, intake processes that require multiple appointments, and eligibility re-

quirements have been shown to be significant barriers even for those who succeed in actually making some sort of contact with a provider (Ebener & Kilmer, 2003b). Parents in our study faced these same bureaucratic hurdles. However, the case management and advocacy provided by child welfare caseworkers and others significantly mitigated these issues for many of the parents. CWS workers and other staff were actively involved in making referrals for clients and at times did most of the “leg and phone work” necessary to secure appointments for assessments and intakes. The availability of court-located prescreening for the severity of the abuse seemed to increase the likelihood of an appropriate referral. In addition, the court-based staff was able to aggressively seek treatment slots, making numerous phone calls and being present when the call was returned. As a result, for the most part, treatment slots were available after only a short (if any) wait. Finally, transportation was frequently provided and an advocate was available to accompany parents to initial intakes and assessments. In short, child welfare involvement brought with it the case management and other resources that were a crucial aspect of some parents’ success, especially given the significant barriers imposed by poverty as described here.

Caring for Children

Previous research suggests that many women fail to seek treatment due to concerns about being unable to secure adequate care for their children, as well as fears about losing custody of their children should CWS become involved (Beckman, 1994; Copeland, 1997; Finkelstein, 1994; Kail & Elberth, 2002; Kline, 1996; Wenzel et al., 1996). For parents in our study, these were largely moot points given that their children were in foster care and that CWS had legal custody of their children; in other words, their children were being cared for and their fears had already been realized. Thus, by and large, parents in this study were not dissuaded from treatment seeking on these grounds.

However, this is not to say that these parents did not have significant and lingering concerns about their children’s well-being.

The notion that treatment affords parents “an opportunity to focus on themselves” misrepresents the experience of many of these parents. In fact, parents had grave concerns about whether children would be harmed in foster care and whether the family would be reunited. Although these worries had a bigger impact on treatment retention and completion than accessing treatment per se, parental stress regarding these issues definitely made it more difficult for some parents to pursue treatment (see also Porter, 1999). These parents seemed to do a calculation that weighed (among other things) the likelihood of success in treatment against the perceived probability that their children would be returned (low) and their beliefs about the impact of a lengthy stay in foster care on their children (likely negative), and decided that treatment wasn’t worth the effort. In other words, entering treatment required some hope that timely recovery was possible and that their children would be returned, and they simply didn’t believe it.

Poverty

The single biggest barrier to treatment for parents in our study can be summarized in a word: *poverty*. The vast majority of parents involved with child welfare are poor (Lindsey, 1994; Pelton, 1989; Shireman, 2003), and the parents in our study were no exception. While the child welfare system was able to blunt the impact of poverty to a certain degree for many parents, especially by providing strong case management (described previously) and some supportive services such as transportation, poverty-related issues remained significant barriers. Moreover, poverty proved problematic for parents in ways not well-detailed in existing research.

Publicly Funded Insurance. The most common poverty-related barrier to timely treatment access for these parents involved the challenges associated with publicly funded health insurance, which pays for outpatient substance abuse treatment in some states. Interestingly, the problem was not that parents did not qualify for coverage (although coverage for drug and alcohol treatment has been se-

verely restricted since these data were collected). Rather, the most frequent delays occurred because of efforts to document eligibility and the “normal” application process. Some parents faced the added burden of having to be the go-between when communication between the treatment provider and the agency providing the insurance did not occur as it should; many had to do this without regular access to a phone or answering machine. In fact, this was the most common breakdown in terms of the case management and advocacy parents received.

Other parents had to leave treatment they had already started when their provider no longer accepted the public insurance, or that insurance no longer covered their provider, due to changes made at the state level. Finally, some parents were hindered by payment issues, either past unpaid premiums or copays or failure to pay for current services. In several cases, providers refused to allow CWS or relatives to cover these costs, which were as little as \$24, because of their belief that to do so was to “enable” the parent:

There was an issue for quite a long time where he couldn't get on the [public health insurance], despite the referral we had put in, because he had a previous unpaid balance or something from three years ago or something like that. It was fairly minor in most people's realm, it was like \$24 or something. That held up him getting into treatment forever. It was months and months. The agency was unable to pay that \$24 because his treatment people said he needed to “be accountable and take responsibility” and to ask him to pay the copay of \$12 a month or whatever it is, when he is working, when he insists he is working day labor, is not outrageous. “And if people keep spoon-feeding him, he won't ever take it.” Ultimately that waylaid him getting into treatment for months.

Employment and Housing. Poverty also served as a barrier to treatment when parents felt discouraged due to concerns about being able to both remain employed and participate in treatment, or

feared losing their subsidized housing should they enter residential treatment. Fears regarding employment were real; one father lost his job because of absences, while the decision of two other fathers to continue working compromised their ability to do treatment. Financial vulnerability was acute for many parents; a handful were homeless at some point during the study. Missing work meant losing their place on the crew; a day's wages meant the difference between having a place to sleep and not. Overlaying this, the irony of which was not lost on parents, was their belief that CWS required them to complete treatment and have both suitable housing and reliable, adequate income for their children to be returned. Many parents saw this as "asking the impossible," as described by one parent who, during the interview, got out his service agreement and started to read:

They want me to participate and complete a parenting program . . . , then they want me to participate in a domestic violence program. . . . And they also want me to complete a drug and alcohol evaluation and complete treatment if it's recommended. [gives a big sigh] then they want to maintain stable employment . . . [Question: Do you work right now?] No I just got laid off, I missed a couple of days, I had to go to court and then in the meantime they needed me to work overtime and I couldn't work overtime because I had a visit with my son and then I had to take off more time to go back to court again. So I kind of got laid, you know they laid me off.

Finally, unstable housing or homelessness and not having a phone or stable address made communication with providers extremely difficult for individuals seeking treatment. One mother who was homeless and relying on friends to relay messages lost a place in a residential facility when she failed to return their call within the required time frame. Another father struggled to schedule an intake given that he had no place the provider could call him back and the staff were rarely available when he was able to call.

Concerns about income, employment and housing were further complicated for *couples* (married and unmarried) who were involved with the child welfare system. We describe this further.

Personal Relationships

Interpersonal barriers also served as an important impediment to treatment seeking for our parents. These have to do with the impact of opposition from family and friends including romantic partners and concern about loneliness and avoidance by friends and coworkers (Beckman, 1994; Kalling Knight, Logan, & Simpson, 2001; Riehman, Hser, & Zeller, 2000; Thom, 1986). Nearly all these issues came into play for the families in our study, albeit in ways not necessarily described in existing research. It is important to note that these seemed to present a particular challenge to the child welfare system.

Extended Family. Numerous studies point to the role of extended family in facilitating denial and delays in treatment seeking due to the shame and embarrassment acknowledgement of substance abuse can bring to a family (Amaro & Beckman, 1987; Beckman, 1994; Beckman & Amaro, 1986). For our parents, the stigma associated with substance abuse is augmented by the shame, guilt, and blame that can accompany becoming involved with child welfare. In theory, the child welfare system is well positioned to tackle this issue head-on by inviting extended family, fictive kin, and other members of a parent's support network to participate in planning for the family by employing practices such as family group conferences (Burford & Hudson, 2001; Connolly, 1999; Hudson, Morris, Maxwell, & Galaway, 1996). In this way, CWS can work with the larger family to mitigate the stigma attached to, and garner support for, the parents' treatment process. This is exactly what happened for some of the families. For example, despite the initial tensions between the maternal and paternal extended families in one of our cases, CWS worked toward an understanding between them so they would be supportive of the parents' mutual efforts toward sobriety.

In other cases, however, CWS failed to deal with family dynamics, as when outrage at what was viewed as an unjustified intrusion by the child welfare system became conflated into thinly veiled opposition to substance abuse treatment on the part of extended family. In still others, the stigma and shame associated with child welfare involvement caused further harm to already strained relationships between parents and extended family; as a result, some parents may have received somewhat less support from extended family than they would have had treatment been sought outside of child welfare involvement.

CWS involvement, and the vagaries of public insurance, also shaped the ability of extended family to offer tangible, instrumental support to parents entering treatment. For example, a mother's eligibility for health insurance, and therefore, treatment, was compromised when her mother occasionally brought her groceries:

I had no insurance. And I just finally got my insurance reinstated after, I turned the application in like May 28th, and I just finally got it reinstated [in August]. . . . I have been borrowing money from my mom. So I had to get my mom to write a letter. She writes a letter, but she puts these amounts on, including random gifts of gas or groceries or whatever. They had to know *how much* gas and grocery money.

Kinship care arrangements frustrated the efforts of other extended family to help, as when grandparents who were providing foster care were unable to transport their daughter, the mother, to treatment due to regulations about the extent of contact between the mother and her children.

Two-Parent Families and Romantic Partners. Dynamics between parents and their partners proved to be an important determinant of treatment access and success and suggests a complexity only implied in extant research on the subject. Research suggests that men are more likely to receive support from a romantic partner for treatment seeking than are women, and that women's recovery is often actively opposed by male partners (Kane-Cavaiola & Rullo-

Cooney, 1991). In general, women in our study were more supportive of treatment for their male partners than male partners were for women. However, the experiences of our families were complicated by the fact that CWS typically required that both partners be making progress towards recovery for a child to be returned if they planned on staying a couple. Ideally, this increases the incentive for partners to support each other's recovery efforts. However, a few parents who were otherwise inclined to pursue treatment were torn by the knowledge that to do so likely meant losing their romantic partner who had refused treatment. And a number of individuals who struggled with treatment, and who faced the prospect of being "left behind" by a partner in recovery, were markedly unsupportive of their partner's treatment attempts. The intersection of emotional and financial ties further complicates the situation for many couples. Overlaying this, the prospect of even short-term separations from their partners caused a great deal of anxiety for many parents. These dynamics were primary in terms of treatment seeking and completion and had a great influence on the ultimate outcome of the case for many of our families.

For some parents, the primary issue was their emotional bond with their partner. The fact that some had few if any support people beyond their romantic partner seemed to increase their dependence and decrease the likelihood they or their partner would enter treatment. This dynamic played out in a variety of ways. Women and men lamented the isolation they expected to experience in residential treatment. In what seems like a paradox at first glance, a father described how the prospect of losing *both* his wife and his child kept him out of treatment. Even though he would presumably be separated from his wife only during his stay in residential, and his refusal to do treatment assured the permanent loss of his child, he simply could not bear "the loneliness." Another mother with few, if any, supports was extremely reluctant to do treatment, as she feared the time away from her partner would disrupt the relationship; she alleged that he had threatened to commit suicide if she entered residential.

Couples were also bound by their poverty, as when it took two incomes (legal or illicit) to cover housing costs and other living expenses. Men, in particular, were vulnerable to homelessness when their partners entered residential treatment. One father had to sleep in a garden shed when he lost access to his partner's housing and disability payments when she entered residential, increasing his need for day labor wages and making it more challenging for him to do treatment. Perhaps not surprisingly, he was ambivalent about his wife's treatment attempts. Another father, whose housing was directly threatened if the mother entered residential, failed to encourage her to pursue treatment. Women, too, felt this dilemma acutely and spoke of both privation and affection when they expressed concerns about leaving their partners "on the streets" to enter treatment.

An interesting strategy was demonstrated by some parents who seemed to bank on the fact that the other parent's "good behavior" would be enough to secure the return of the child, making it unnecessary for them to access treatment services. The parent who had forgone treatment would then be either openly reunited with the family or simply wait until CWS had closed the case and then rejoin his partner and child. Although not in recovery themselves, these partners were often, at least initially, openly supportive of their partners' treatment.

Negative Consequences of CWS Involvement

The downside of the supportive services made available by virtue of CWS involvement suggests a final addendum to existing research. While the case management and advocacy provided by the CWS significantly mitigated many barriers for families, this attention from the caseworker, court staff, and others had a negative aspect in terms of increasing the stress experienced by parents (especially given concerns about their children) and the burden of the myriad other services mandated by the court. This played out in a variety of ways.

First, the court experience itself produced a great deal of anxiety for parents. One parent described her feelings in the aftermath

of the preliminary hearing as “being in a haze, confused. . . . We waited to get called up and I don’t know, it was kind of just a whirlwind, it was overwhelming, yes that was pretty much just a fog.” In at least two cases, the resulting fear meant that parents failed to take advantage of the special court located assessment and advocacy program:

[Question: Do you remember right up front you had those fit people intervene at court to help you get assessments?] Yes, but I didn’t really, I said no, because I thought they were out to get me. I thought everybody was out to get me. So I was like “no way.”

Second, the complexity introduced by the fact of multiple staff and providers created problems for some families in their efforts to access treatment. For example, the division of labor between CWS caseworkers and other “advocates” was not always clearly specified. This was a problem particularly when parents were not able to access treatment via the first referral and some follow up was necessary; these parents often languished until the caseworker “noticed” they were not attending treatment. Treatment providers rarely notified the caseworker if the treatment agency was unable to admit the parent into treatment.

Finally, and of even greater importance, was the challenge of juggling the myriad appointments and service requirements. ASFA makes it extremely difficult to stagger services to parents given the necessity of making progress within the timelines. Numerous parents talked about the difficulty of simultaneously attending treatment and the other mandated activities such as parenting classes, domestic violence services, court hearings, and visits with their children. Parents who had to work or were without adequate transportation found accomplishing everything that was required especially challenging:

You know they [CWS] expect me to ride the bus down there [to CWS] and then ride the bus back. Well, it takes two hours to ride the bus there and two hours to ride the bus

back. That's four hours out of my day and then I have to spend two hours down there [for visitation] well that's six hours out of my day. And that monopolizes a lot of time.

Another parent stated,

Having to work on a daily basis and taking time off to do this and do that, I was giving myself a bad name. They [the day labor people] stopped giving me some of the work because some jobs I have to do 12-hour shifts but I can't do that jumping through all the hoops they want me to jump through . . . I've been able to accomplish a couple of things. One of the hardest has been finding an evening parenting class that doesn't conflict with alcohol classes. That's one reason I wanted to get into the in-treatment. They don't have them [parenting classes] on Saturdays. They have them during the day but that's when I have to work or they conflict with my alcohol class.

In summary, the child welfare system assisted parents in overcoming many of the most common barriers to treatment such as denial, lack of information about treatment options and numerous programmatic impediments. For example, case management and transportation assistance were instrumental to parents' ability to surmount obstacles such as waiting lists and to actually make it to appointments. However, even high-quality casework was of limited effectiveness against the "normal" delays and other vagaries associated with reliance on public assistance (such as changes in insurance coverage) and poverty proved a significant impediment in other ways. Interpersonal barriers such as opposition from extended family and the dynamics between parents and romantic partners (including but not limited to biological parents) illustrate the complexity of attempts to facilitate treatment access for these adults. Finally, involvement in the child welfare system itself seemed to frustrate efforts by some parents to access treatment.

Discussion

The previous section compares the treatment seeking experience of parents who are involved with the child welfare system with the literature on barriers to treatment among the general substance-abusing population. In what follows, we discuss the similarities and differences between the issues facing persons with substance abuse issues who are involved with the child welfare system and those who are not, and the implications of our findings for improving services to these families.

The bureaucratic and programmatic barriers prominent in much of the literature on treatment access pertain to anyone seeking treatment that is reliant on public rather than private services. The experiences of parents in our study confirm existing research on the value of working with a case manager or other supportive and knowledgeable individual to overcome logistical hurdles (McKay, Gutman, McLellan, Lynch, & Ketterlinus, 2003; Morgenstern et al., 2003). Aggressive case management and provision of related services such as transportation mitigate, to a great degree, an array of personal and bureaucratic barriers to treatment. Thus, it would seem that service models, which allow staff to attend to the “busy-work” of getting parents into treatment, are likely to be important for these families.

Substance-abusing adults involved with the child welfare system are typically poor and frequently face additional challenges such as mental health issues, domestic violence, law enforcement involvement and their own histories of abuse and neglect. In this way, they are not unlike many individuals who are in need of substance abuse treatment who are not involved with child welfare (CASA, 1996; Jayakody, Danziger, & Pollack, 2000; Metsch, Rivers, Miller, Bohs, McCoy, Morrow, Bandstra, Jackson, & Gissen, 1995; Westley, 2001). Poverty—and the inadequate transportation, communication, and housing that often come with it—make accessing treatment unduly challenging for a large portion of individuals

who need it. Concerns about maintaining employment and subsidized housing and accessing child care services discourage individuals from seeking treatment. The fact that, despite the considerable resources available through the child welfare system, a number of parents failed to access treatment speaks to how significant these barriers are; and many low-income individuals likely attempt to access treatment without these substantial supports.

A further consideration is the fact that the vast majority of these families have multiple problems and, therefore, face mandates to participate in numerous services. While we highlighted the tensions this creates for parents in our study, many of these same dynamics likely apply for parents dependent on Temporary Aid for Needy Families (TANF) as well, given the timelines associated with that program. The requirement that parents must deal with substance abuse and mental health issues, obtain needed job skills, and locate adequate housing within the two-year time limit in place in many states is no doubt daunting for many TANF recipients and service providers alike (Gutman, McKay, Ketterlinus, & McLellan, 2003; Jayakody et al., 2000; Morgenstern, Nakashian, Woolis, Gibson, Bloom, & Kaulback, 2003). For helping systems themselves not to serve as barriers to treatment, coordination and communication are essential (Green & Rockhill, 2004; Young & Gardner, 2002). Again, this speaks to the importance of effective, well-implemented wrap-around services and case management.

The success the child welfare system experienced with parents who, prior to child welfare involvement, appeared “not yet ready to give up drugs/alcohol” speaks to the merit of “mandated” treatment found in other studies (Hser, Maglione, Polinsky, & Anglin, 1998; Wild, Roberts, & Cooper, 2002), and to the value of major “wake-up calls” that can overcome denial. Mothers, in particular, seemed to embrace the opportunity to enter treatment when ordered to do so by the court and faced with the possibility of losing their children. However, the stakes may be considerably higher for child welfare-involved mothers, which may complicate the effectiveness of this form of coerced treatment. For example, while

mandating treatment had a generally positive impact, the experience of our parents also speaks to the fine line providers must walk when they employ reunification as a motivation or a carrot; parents may lose hope that the child will be returned to them and decide to forgo treatment as a result. This suggests the importance of providing ongoing emotional and personal support to parents in the face of this mandate (Green, Rockhill, & Burrus, 2008). Family treatment drug court models, in which the judicial system is highly involved, but which typically include a "team of support" for parents, may represent a promising intervention that can balance coercion with positive support.

The challenges of dealing with extended family and romantic partners are no doubt an issue in the broader substance-abusing population as well. Involving extended family is complicated in unique ways, however, by child welfare systems that tend to emphasize engaging kin and other natural supports in planning for and supporting parents and children. Unfortunately, for the majority of families in our study, this occasioned a missed opportunity to build on the strengths of the extended family. In the worst cases, CWS unintentionally aggravated existing tensions and diminished the ability of family to provide emotional and instrumental supports. This happened for a variety of reasons. The rules and regulations that come into play because of child welfare involvement circumscribe many of the most common ways in which family members provide support to each other. In addition, the effect that the shame and stigma associated with both substance abuse and child maltreatment have on family dynamics is not always adequately attended to by caseworkers and treatment counselors.

We found that the response of child welfare to romantic partners was problematic as well. The legal and practical requirement for child welfare and the courts to work with both parents, and the impact romantic partners can have on recovery, suggests the necessity of tackling the issue head on. However, child welfare frequently failed to do so; we found that the impact of partners on each other's treatment received little attention. In addition, there

was a failure to acknowledge the very real impact separation was likely to have on instrumental issues such as a parent's access to housing. This is perhaps due to the fact that child welfare, the courts and treatment have few tools with which to formally "manage" the relationship other than to simply encourage couples to either both pursue treatment or to separate, short of making some sort of separation a condition of reunification. These complications are further exacerbated by child custody issues (e.g., if there is a "race" between parents to comply with the case plan and obtain custody) and by the ambiguous legal status of nonmarital partners, who may be required to obtain services but who are often not a part of the state's mandate to provide support to the family.

Making the choice between maintaining custody of one's children and staying with one's romantic partner was a cause of significant anxiety for a number of parents. This tension does reflect the choice, although with somewhat less serious consequences, that many substance-abusing individuals must make between sobriety and staying with a partner who continues to abuse drugs or alcohol. In addition, it underscores the importance of being able to provide family and couples therapy, and of maintaining a broad and inclusive definition of "family." Unfortunately, many CWS workers lack the skills, training or time to provide the "family system interventions," such as family group decision making, suggested by these issues.

Conclusion

The majority of parents in our study successfully accessed substance abuse treatment due in no small measure to the assistance afforded them by virtue of their involvement with the child welfare system, and most notably, the efforts of individual caseworkers. Most of the barriers cited in the literature existed for parents in our study, although not all proved to be significant. However, we found that parents were frequently frustrated in their attempts to access treatment, and their experiences in making these attempts expands

our understanding of the mechanisms by which certain barriers impede treatment seeking as well as adding to the list of those barriers. For example, poverty represented a considerable obstacle to treatment in spite of the assistance provided by caseworkers, and our study provides new information regarding some of the ways in which a lack of income and attendant difficulties impede treatment.

Many of the lessons learned, outlined previously, clearly hold for substance abusers in general; however, challenges specific to child welfare-involved parents must be considered in developing services for this population. An additional consideration in a discussion of treatment access is the length of time it takes to be able to actually enter treatment once someone has decided to do so. The issue of *timely* treatment is particularly acute for parents involved with CWS given the ASFA timeline, especially given the fact that the vast majority of these families have multiple problems and, therefore, face mandates to participate in numerous services. The ASFA timelines preclude staggering services in many instances, meaning that parents must participate in a number of activities simultaneously. Aggressive case management and close coordination between the various service providers is crucial in this context. Unfortunately, history and research (DHHS, 1999) suggest that this may present a particular challenge for child welfare and substance abuse treatment.

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